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ABSTRACT

A review of the literature on sexual intimacy in psychotherapy revealed that male therapists were involved in sexual intimacies significantly more than were female therapists (approximately nine percent versus two percent). The research clearly shows that the overall effects of sexual intimacy are negative, ranging from clients experiencing difficulty in trusting a subsequent therapist to clients committing suicide. The sexualized therapeutic relationship appears to arise out of the vulnerabilities and/or conflicts of both the client (transference) and the therapist (countertransference). Awareness of the difference in status and power in therapy focuses on the abuse that may occur in the present, real relationship. In addition, the cultural situation allows male therapists' countertransference needs to be acted out sexually. Two steps appear necessary to the prevention of therapist-client sexual intimacy. First, the therapist should take a diagnostic approach to recognizing clients who are likely to be vulnerable to acting out sexually in therapy. Second, the therapist needs to take regular self-inventories of his or her own intimacy needs and to be aware of increased vulnerability in times of stress. Unfortunately, much of the research has failed to uncover the distinguishing characteristics of the sexually intimate therapist. (Author/NB)

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EMPIRICAL LITERATURE AND THEORETICAL ASSUMPTIONS

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for the Degree of Doctor of Psychology

ROSEMEAD SCHOOL OF PSYCHOLOGY

BIOLA UNIVERSITY

STEVEN MERRILL SCRUGGS

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LITERATURE AND THEORETICAL ASSUMPTIONS

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SEXUAL INTIMACY IN PSYCHOTHERAPY: A REVIEW OF THE EMPIRICAL
LITERATURE AND THEORETICAL ASSUMPTIONS

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Abstract

Sexual intimacy in psychotherapy was reviewed. Male therapists are involved in sexual intimacies significantly more than female therapists (approximately 9% vs. 2%). The effects are overwhelmingly negative. The sexualized relationship arises out of the vulnerabilities and/or conflicts of both the client (transference) and the therapist (countertransference). Also, awareness of the difference in status and power in therapy focuses on the abuse that may occur in the present, real relationship. Moreover, the cultural situation allows male therapists' countertransference needs to be acted out sexually. A diagnostic approach was recommended to identify clients that are likely to act out sexually. Further, therapists need to take regular self-inventories of their intimacy needs, to be aware of increased vulnerability in times of stress. Finally, much of the research has failed to uncover the distinguishing characteristics of the sexually intimate therapist.

Sexual Intimacy in Psychotherapy: A Review and Analysis of the Empirical Literature and Theoretical Assumptions

Five areas have been identified as constituting an impaired practitioner (J. Guy, personal communication, February 20, 1986). These are sexual intimacy with clients, substance abuse, mental disorders, burnout, and deterioration due to age (no forced retirement). Sexual intimacy with clients has become an area of particular concern both within the profession and for the general public. In fact, the previous insurance carrier for APA declined to provide further coverage to psychologists due to the growing litigation in this area (Asher, 1976). Obviously, there is a need for the profession to understand and deal with this escalating problem.

The goal of this paper is to review the current research on the incidence and the effects of sexual intimacy in psychotherapy. In addition, the theoretical concepts of client transference and therapist countertransference will be evaluated to determine how well they can account for the empirical research in the area of sexual intimacy. Finally, some strategies will be suggested in dealing with this problem within the profession and an attempt will be made to outline some areas that need further research.

Incidence of Sexual Intimacy

Problems in Definition

In evaluating the incidence of sexual intimacy, it is necessary to have a clear picture of what is being measured.

Sexual intimacy in psychotherapy has been defined as any physical contact between client and therapist which intends to lead to arousal or satisfaction of sexual desire (Holroyd and Brodsky, 1977). The first national research efforts included such behaviors as passionate kissing, oral/genital contact, mutual masturbation, petting, anal intercourse, and/or sexual intercourse in the definition (Holroyd and Brodsky, 1977; Kardener, Fuller, & Mensh, 1973; Stone, 1980). Later researchers have generally restricted the definition of sexual intimacy to genital stimulation and/or sexual intercourse.

The behavior in question in these definitions is kissing. Some authors have tried to handle this ambiguity by including passionate kissing as sexual intimacy (e.g. Kardener, Fuller, & Mensh, 1973; Stone, 1980). However, it is questionable if kissing is ever appropriate in the therapist-patient relationship. Given the social/cultural context of the United States, kissing is likely to have sexual connotations. Of course, some behaviors are even more ambiguous as to whether they are erotic or nonerotic, such as hugging, and are even more difficult to determine. Later researchers have chosen to use the uncontestable definition of sexual intimacy of genital stimulation and/or intercourse, apparently to avoid any ambiguity. This unquestionable definition is used for the purpose of this discussion, recognizing that this may overlook behavior that could be defined as sexually intimate.

Another problem in defining sexual intimacy in psychotherapy

is the time frame within which it occurs. Researchers have only studied sexual intimacy within three months of termination. Although this three month figure is entirely arbitrary, it does suggest prior sexualization of the therapeutic relationship. There are a variety of opinions as to whether sexual contact with a client is ever appropriate. Some authors have suggested that such contact is appropriate only if therapy is immediately terminated and referral is made. Others feel that sexual intimacy is never appropriate with a client (e.g. Langs, 1973).

Historical Review

As early as 1915 Sigmund Freud noted the strong pull of clients toward sexual contact. He strongly warned analysts to resist such advances and temptations for such "conquests," pointing out the "transference" and "countertransference" roots of such activities. Although he did not note any particular "transgressions" among current analysts, it appears that he was afraid that it would become an issue. This is particularly true in light of Freud's fear of how psychoanalysis would be regarded among the scientific community. Surprisingly, Freud later (1922) seemed to endorse the marriage of a former trainee (H. W. Frink) who reportedly fell in love with a patient (Jones, 1961, p. 435).

Over the years, many other writers have provided anecdotal information regarding sexual contact between therapists and clients (e.g. Tower, 1956; Masters and Johnson, 1970; Chesler, 1972). Two little cited surveys were the first attempts to take

an empirical approach to determine the incidence of sexual intimacy in psychotherapy. In 1938, Glover (1955) sent a complicated survey to members of the British Psychoanalytic Society. There was a surprisingly high return rate of 83 percent. Of those who responded, none of them acknowledged sexual intimacy with analysands. In light of later research, this finding appears to have been an artifact of the strong professional and theoretical taboo against losing a position of neutrality with analysands, rather than an accurate measure of incidence. In an unpublished 1968 survey of the members of the Los Angeles Psychological Association, Forer (cited in Pope, Keith-Spiegel, and Tabachnick, 1986) found that 17% of the men and none of the women in private practice indicated that they had engaged in sexual intimacies with clients. Also, men who worked in institutional settings reported that they had engaged in no sexual contact with clients. These results should be treated with caution for two reasons. First, the results are lower (0%) and higher (17%) than any later results. Second, the sample in each of the studies may have been limited. The sample bias in each study may have been the reason for the extreme outcomes. Therefore, generalization of these results may be restricted.

Pioneering work was done in this area by Kardener, Fuller, and Werish (1973). Using an anonymous questionnaire, information was received from 460 physicians (114 psychiatrists) out of a random sample of 1,000 California physicians. Their findings were that

13 percent of the respondents indicated that they engaged in "erotic behavior" with patients and five percent engaged in "sexual intercourse specifically" (p. 1077). As noted above, their findings showed that there was a broad range of erotic behavior that could be defined as sexually intimate.

The first nationwide survey of psychologists attitudes and practices regarding erotic and nonerotic physical contact with patients was by Holroyd and Brodsky (1977). They used the Kardener et al. (1973) survey instrument, substituting psychologist for physician. Out of 1,000 surveys randomly distributed, 666 were returned by subjects who engaged in psychotherapy. Respondents fell into the following primary therapy-orientation categories: psychodynamic, 185; behavior modification, 45; humanistic, 48; rational-cognitive, 29; and eclectic, 342. Seventy-six percent treated sexual problems in their practices at least occasionally.

Five questions were used to assess the amount of erotic contact between therapist and patient. Percentages were based on the number of people who responded to each question rather than the total number of subjects, perhaps resulting in inflated results. Nevertheless, they are striking. For female therapists, 1.9% admitted to having engaged in erotic contact with clients; of male therapists, 10.9% fell into this category. Less than one percent (.6%) of female therapists, but 5.5% of male therapists engaged in intercourse during therapy. When those therapists who

had intercourse with clients within three months after terminating therapy were included, the totals were 1.0% of female therapists and 8.1% of male therapists. Not all of the respondents reported the number of patients and number of times they engaged in erotic contact or intercourse. Of those who did report, 80% had contacts with more than one patient, consistent with Butler's (1975) finding of 75%, and they tended to repeat these contacts. Finally, few women (1%) and few men (4%) reported that they had ever had any same-sex erotic contact.

Obviously, there was a significant difference between male and female therapists. This finding was similar to Perry (1976), who found that female physicians (including psychiatrists) rarely engaged in erotic contact with clients. Therefore, overall percentages may be misleading. However, with an increase of women in the profession, this trend may balance in the future. In addition, there were no significant differences according to therapy orientation. Finally, there is evidence that suggests that these estimates were conservative. Respondents who had intercourse waited longer to reply, as evidenced by the order in which the questionnaires were returned. Four questionnaires of therapists who had sexual intercourse with clients were returned in the first 400 replies (1%) and 17 in the next 303 replies (5.6%). The nonresponse bias probably lowered these estimates.

Pope, Levenson, and Schover (1979) studied sexual intimacy in psychology training and psychotherapy. Their national sample

included 305 respondents who were psychotherapists. Sexual contact was defined as "intercourse or genital stimulation" (p. 684). Again, there were significant differences between men and women. Male psychotherapists reported significantly more sexual contact with clients than female psychotherapists (12% vs 3%, overall 7%). They did not include a breakdown between psychotherapists and psychologists in general in one striking result. As professionals, those who had received their doctorates more recently were almost four times more likely to have had sex with students or clients (22% vs 6%). It is unclear, however, if this result applies to therapist/client sex, teacher/student sex, or both.

As with Holroyd and Brodsky (1977), it is unlikely that respondents claimed such contact at a rate greater than the occurrence, suggesting that these findings are also conservative estimates. Pope et al. (1979) note that with "both the current and the previous survey, respondents claiming sexual contact were significantly later in responding, suggesting that the nonresponse bias is toward underestimating the sexual contact" (p. 687).

Bouhoutsos, Holroyd, Lerman, Forer, and Greenberg (1983) sent questionnaires to every licensed psychologist in California (N=4385) asking them to report incidence and effect of previous therapist's sexual involvement on their clients. Overall, 704 licensed psychologists (16%) returned the survey. Information regarding the nature and effect of sexual intimacy between

psychotherapists and patients were reported by 318 psychologists. These psychologists had treated 559 patients who had sexual involvement with a previous therapist.

Bouhoutsos et al. (1983) found that 96% of the (previous) therapists who engaged in sexual intimacies were male, and 4% were female. The majority of sexual relationships with male patients (58%) also involved male therapists. Further, of the reporting therapists, 4.8% of the male respondents and .8% of female respondents in the entire sample of 704 reported having engaged in their own sexual intimacies with patients, a significant gender difference.

Pope et al. (1986) studied the continuum of sexual attractiveness to sexual intimacy with clients. In their national survey of 1,000 psychologists in private practice (members of APA Division 42), they had a 57.5% return rate (N=575). Although most psychologists (95% of men, 76% of women) admitted sexual attraction to clients, the large majority of respondents had never acted out sexually with their clients (90.6% of men, 97.5% of women). They further note that:

Sexual intimacies with clients occurred rarely (once or twice) for 5.6% of the sample, occasionally (3 to 10) times for 0.7%, and frequently (more than 10 times) for 0.2% (one respondent). Male therapists engaged in sexual intimacies with clients more often than did female therapists (9.4% vs. 2.5%). (p. 152)

The results clearly show that the majority of psychologists are not involved in sexual intimacy with their clients. However, there is a significant minority who do have this type of sexual

contact. Therefore, since this is happening within the profession, what effect does the sexualization of the therapeutic relationship have on the client and the therapist?

Effects of Sexual Intimacy in Psychotherapy

Although most authors have argued that sexual intimacy in therapy is detrimental, some therapists have claimed that it is either neutral or beneficial (e.g. Romeo, 1978). McCartney (1966) and Shepard (1971) maintained that sexual intimacy could help the client, since it promotes her self-esteem, increases her sexual knowledge and experience, and can be part of a positive, non-exploitive relationship. McCartney relied exclusively on his own clinical experience to justify his claims. His objectivity was questionable, however, because his own therapeutic interventions included sexual intimacy with clients. To paraphrase Masters and Johnson (1970), it is very difficult to be objective and be in bed.

Shepard (1971) used a "case study" approach. It seems that he magnified his limited support for sexual intimacy in psychotherapy in order to gain attention or for sake of argument. This posture is termed the entrepreneurial gadfly syndrome (T. Morscheck, personal communication, May 28, 1986). This syndrome is evident in Shepard's greatly qualified conclusions, where he notes "that owing to the possessiveness, confusion of roles, guilt, and shame on the part of the therapist, such involvement is, generally speaking, not a good idea" (p. 208).

Taylor and Wagner (1976) noted that 21% of the cases they reviewed reported positive effects of the relationships that included sexual intimacy. They suggest that what is "real" or "transference" love is difficult to distinguish, since all romantic relationships include fantasies and distorted expectations. Therefore, they suggest that sexual intimacy in psychotherapy may be little different than sexual intimacy in other relationships.

Two of the arguments that have been used by attorneys defending therapists accused of sexual contact with clients (Bouhoutsos et al., 1983) highlight the issues raised by those who defend sexual intimacy in psychotherapy. First, the therapist was seduced by the patient. Second, sexual intimacy may be beneficial rather than harmful. In part, these arguments reflect the prevailing attitudes of society toward casual sexual relationships. Since psychologists are likely to continue to reflect society's attitudes, these arguments need to be addressed. Further, appropriate standards of practice need to be guided by empirical evidence, as traditional morality is less likely to determine these standards.

In the memorandum opinion of Judge Vernon G. Foster (Dresser vs. Board of Medical Quality Assurance, State of CA, C 302489), seductiveness of the patient is irrelevant, as therapist-patient sexuality is analogous to parent-child sexuality. By that analogue, sexual intimacy between patient and therapist is not

viewed as a consensual act between adults. Kardener (1974) draws the parallel between incest and patient-therapist sexual contact:

The child involved in incest is denied this vitally needed person, and this denial contributes to the emotional trauma of incest. In an exactly parallel way the physician, as a source of healing, support, and succor, becomes lost to his patient when he changes roles and becomes lover. (p. 1135)

Closely related to the issue of "client seductiveness" is the trust that is inherent in the therapist's role. Masters and Johnson (1970) state that sexual intimacy with clients is a great breach of the trust that goes with that role. They believe that therapists who become sexually intimate with their clients should be charged with rape.

The more important question, though, is how detrimental such relationships are. Freud stated that a client/therapist sexual relationship would be "a complete overthrow for the cure" (1915/1963, p. 174). However, if there is no empirical base for the need to restrict sexual intimacy in psychotherapy, it is a moral or theoretical standard that could be considered arbitrary. Does the research support the theoretical and/or moral presupposition that sexual intimacy in psychotherapy will result in negative effects?

Negative Effects for Clients

A number of studies indirectly studied the effects of sexual intimacy on the client, but give some useful information. For instance, though Belote (1974) was studying characteristics of clients rather than the effects of the sexual relationship, she

also noted that the long-term effects were overwhelmingly detrimental to the client. Butler (1975) studied characteristics of therapists who were sexually intimate, but also found that patients involved in sexual intimacies with therapists had excessive conflict and psychological pain. Further, Durre (1980) reported symptoms ranging from anxiety and anger to severe depression and suicide attempts, resulting in divorce, hospitalizations, and shock treatments. She concluded that "sexual interaction between client and therapist dooms the potential for successful therapy and is detrimental, if not devastating to the client" (p. 243).

D'Addario (1977) advertised in national women's magazines to gain a broad sample of women who had been sexually involved with their therapists. Out of this sample, she presented case studies of four women who met specific criteria regarding length of therapy, therapist's qualifications, type(s) of sexual contact, and duration of sexual contact. All of these women experienced outrage and hurt at the termination. One woman became severely depressed; another woman felt that she had neglected her husband and children; the third woman's sexual dysfunction was not "cured" by her therapist, as he thought he would do; and the fourth woman made a serious suicide attempt. There was also a significant amount of sexual dysfunction on the part of the therapists: impotence, priapism, and premature ejaculation. This confirms the fear of Fromm-Reichmann (1960; p. 127) that the therapist might

indirectly cause the client to fear that she was not attractive or desirable because of the therapist's sexual dysfunction, thus increasing the client's distress.

Bouhoutsos et al.'s (1983) primary goal was to assess effects of sexual intimacies of clients, but respondents in their survey self-disclosed their own sexual intimacies at a level nearly consistent with previous findings (4.8% of male therapists; 0.8% of female therapists). Also, they pointed out that therapists who had sexual involvement with clients reported negative effects of such encounters significantly less. It seems, then, that there may be a considerable amount of bias in how therapists report negative effects of sexual intimacies with clients. In addition, the sample did not include those who were too traumatized to return to therapy or those who had no negative results and did not need to return to therapy. Only those patients returning to therapy after having been sexually involved with a former therapist were reported on.

Despite these limitations, the results were significant. Of the 559 patients described, 90% were reported to have suffered some ill effects. These negative effects ranged from difficulty trusting a new therapist to committing suicide. Therapist behaviors that caused ill effects ranged from merely proposing sexual relations to intercourse. Bouhoutsos et al. (1983) reported that sexual contact was especially disruptive if it began early in the relationship (the majority of cases) and if it had

been initiated by the therapist (also the majority of cases).

Feldman-Summers & Jones (1984) compared women who were involved in a sexual relationship with a therapist, women who were involved in a sexual relationship with another type of health care practitioner, and women who were not sexually involved with their therapists. Women who had had sexual contact with their therapist reported more anger and mistrust of men and therapists and more psychosomatic symptoms 1 month after therapy than did women who had not had sexual contact their therapists. Also, the impact of sexual contact with other health care professionals (primarily physicians) was as negative as sexual contact with therapists.

Bouhoutsos (1985) describes the feelings of guilt and shame that many clients have after being sexually involved with their therapists. Not only are such clients hesitant to make it known that they have been coerced, but also they feel powerless to negotiate the systems of ethical and legal recourse. As one might expect, many are angry at the mental health profession and are cynical that professionals will investigate and punish colleagues. Some clients even have guilt feelings about being seductive and assume that they are responsible for what resulted.

Zelen's (1985) review of most available clinical reports indicated that sexual intimacy in psychotherapy had left most of these female patients distrustful of therapy and angry at being exploited. Further, they had feelings of being treated as a sexual object instead of as a person, resulting in even lower

self-esteem than when they began therapy. They also had heightened sexual difficulties and increased feelings of ambivalence about themselves.

Pope et al. (1986) state that "the sequelae of a patient's sexual relationship with a therapist may form a distinct syndrome" (p. 148). They note cognitive dysfunction, identity and boundary disturbance, ambivalence, lability of mood, inability to trust, sexual confusion, suppressed rage, and feelings of guilt and emptiness. They conclude that the "Therapist-Patient Sex Syndrome" appears to bear similarities to borderline (and histrionic) personality disorder and various stress syndromes. However, this explanation fails to account for an important alternative hypothesis. It is inaccurate to assume that all of these symptoms result exclusively from the client/therapist sexual relationship, as Pope et al. (1986) imply. It is difficult to determine what characteristics (or symptoms) the client brought into therapy and which were the result of the sexual intimacy. However, it seems more likely that the stress-like symptoms are related to the acute situation, i.e. the sexualized therapeutic relationship. On the other hand, the symptoms that appear to be like a personality disorder are more likely a result of stable personality characteristics, as will be discussed in a following section.

Negative Effects for Therapists

Butler (1975) reported that 95% of the therapists that he

interviewed reported both positive and negative effects. Some of the positive effects implied dual relationships (e.g. marriage, friendship) which are ethically questionable (Pope, 1985d). However, other outcomes (e.g. feelings of growth, deep emotional/spiritual connections, and respect for each other) could be interpreted as contributing to therapeutic result and personal growth. The negative effects for the therapists in Butler's study were that 95% reported fear and/or guilt as well as a desire to terminate the sexual relationship.

As noted above, D'Addario (1977) found that the therapist/client sexual relationships had a significant amount of sexual dysfunction on the part of the therapist. This would seem to be threatening to the therapist who was supposed to be in the role of "expert," heightening his sense of inadequacy. Also, he would be forced to recognize that he had not been helpful to his patient by making her feel sexually inadequate.

Other negative effects include censure by colleagues, either informally or formally. As a result, the therapist might experience a range of consequences from failure of colleagues to refer to the therapist to removal of the therapist's license. Further, it is increasingly possible that a therapist that is sexually intimate with a client could be faced with a civil suit by the client or anyone directly related to her. This could result in negative publicity, a large malpractice debt, and inability to obtain further malpractice insurance (Pope, 1984).

Criminal proceedings are also an increasing possibility, as one sentence of 5 years in prison has been issued by the courts (Bouhoutsos, 1985).

Criminal legislation in the area of sexual intimacy is an evolving issue. An unsuccessful effort was made to enact legislation for criminal penalties against sexually intimate therapists in California (i.e. the Diane Watson Bill). There are presently no criminal penalties for non-forcible sexual intimacy with a competent adult client in California (Howard Levy, personal communication, June 3, 1986). However, the extent of criminal charges has not been conclusively determined at this point in time. Insurance companies are strongly supporting stiff criminal charges for sexual intimacy in psychotherapy. Criminal legislation would take this issue out of the civil courts, ending civil suits. Therefore, insurance companies would not have to pay civil (malpractice) damages that cost a great deal. The status of criminal consequences for sexual intimacy is likely to change and will probably be refined in the next few years.

It is by now obvious that sexual intimacy in psychotherapy leads to negative outcomes for both clients and therapists. In the next section the author will attempt to decipher what predisposes clients and therapists to become involved in sexual intimacies from both a conceptual and empirical standpoint.

Transference/Countertransference and Status/Power: Do These
Theoretical Concepts Account for the Data?

Therapists who have written about sexual intimacy in psychotherapy have conceptualized this as evolving from two sources. Traditionally, sexual contact during the course of therapy has been viewed as the result of the transference needs of the client and countertransference needs of the therapist, in contrast to a mature love relationship. Even more empirical approaches have to some extent assumed that these constructs were the underlying explanatory dynamics (e.g. D'Addario, 1977; Stone, 1980). On the other hand, many recent researchers have suggested that sexual intimacy in psychotherapy is largely the result of men taking advantage of the status/power differential in light of their sex and role as therapists (e.g. Holroyd and Brodsky, 1977; 1980; Bouhoutsos et al., 1983). It is the goal of this discussion to determine if these theoretical constructs can account for the data. Further, these two theories will be evaluated as to their respective contributions in sensitizing researchers to different aspects of the sexualized therapeutic relationship.

Transference and Status: The Client's Role in Sexual Intimacy

The definition of what constitutes transference has developed over the years since Freud. However, transference is still thought of as a process wherein the client projects onto the therapist psychological characteristics, dynamics, attitudes, and feelings which were originally experienced during childhood with

the significant attachment figure(s), typically the parents (e.g. Langs, 1973). Thus, transference is the transfer of the client's unresolved conflicts onto the present relationship with the therapist. Since these conflicts are thought to be from early childhood, they are irrational and continue to limit the person in the present (Hedges, 1983). From this viewpoint, sexual intimacy is not seen as evolving out of the present, realistic relationship between the client and the therapist, but instead from the unresolved conflicts of the client. Therefore, an attempt will be made to identify if the characteristics in clients that predispose them to be involved in sexual intimacy can be accounted for by the concept of transference. It is important to note that this conceptual understanding is not meant to assign guilt to the client who may be victimized by such a relationship, but to gain deeper understanding of the dynamics of the relationship as it develops in the therapy.

People in our society often confuse intimacy with sex (Forer, 1972). Because society encourages adults to engage in one form of contact (sex), this gets confusing when another form is desired, e.g. being held. Therefore, many persons indulge in sexual intercourse when the need for cuddling has been suppressed out of fear, anxiety, or shame. A similar situation occurs in therapy. A client's primitive needs are mobilized through the acceptance, openness, and trust in the therapeutic relationship. However, these needs are confusing and therefore are expressed through

sexual contact with the therapist.

Of those women who have been willing to report their sexual intimacies with therapists, at the time of these sexual intimacies they were in their early to mid-twenties with a mean age of 22 and a median age of 24.5 years (Belote, 1974; Stone, 1980). They were also approximately 16 years younger than their therapists (Belote, 1974; D'Addario, 1977). Thus, these women were in a "subordinate" role by (questionable but entrenched) societal standards not only in sex and role, but also in terms of age. It would appear that these older, higher status therapists would create a strong pull for the transference issues from these clients, which would be expressed sexually.

Belote (1974) tested 25 women who were involved in sexual intimacies with their therapists in an attempt to verify previous clinical observations by Chesler (1972). She used the Shostrom Personal Orientation Inventory (1968) and the Gough California Personality Scale (1969). Two-thirds of the women studied by Belote were unmarried, separated, or divorced and many were experiencing a life-crisis following a divorce, separation, or an unhappy affair. They were lonely, searching for acceptance and friendship. Belote also found that they were high in traditional feminism, had low self-regard, low self-actualization, and that they were mainly "other-directed" people. These women were very vulnerable and would be likely to attach themselves to a "strong" person such as a therapist, in order to gain a sense of strength

and completeness, much like a child attaches to a parent.

Unfortunately, there were methodological difficulties that limited these results. The subjects were instructed to fill out the two tests as they would have done upon beginning therapy (a range of 1 to 31 years ago, median of 3 years and 5 months). Recollection after such a long period of time could have been distorted. In such a retrospective analysis, it is also impossible to know if these characteristics occurred before the sexualized therapeutic relationship, or as a result of it. In addition, there was no control group of women who had sought therapy and had not had a sexual relationship with their therapist. Most alternative hypotheses could have been ruled out by such a control group. Therefore, while by their own report these women who were sexually intimate with their therapists had the characteristics that Belote postulated, there is no assurance that these characteristics are distinctive to such women.

Belote also found that these women had very low acceptance of their own aggressive impulses. Further, Belote reported that many of these women were sexually dysfunctional, i.e. nonorgasmic, like D'Addario (1977), who used in-depth interviews with four women who were sexually intimate with their therapists. The first finding suggests that these women would be likely to act out aggression in indirect ways, e.g. sexually. The second finding suggests that these women would be vulnerable to a strong (transference or high status) figure who could "magically" solve their sexual

dysfunctions.

Butler and Zelen (1977) noted that the sexual relationship with the therapist arises out of the client's neurotic needs. Zelen's (1985) review characterized the patient as "vulnerable" and concluded that "the sexually vulnerable patient is like the child who is sexually molested. She may have incest fantasies, she may be dependent, she may have inadequate ego development and be narcissistic and acting out" (p. 182). Again, it is likely that the client is acting out issues that they brought into the therapy situation (transference), rather than acting only out of the real, present relationship with the therapist. Also, her dependence could be relieved by attaching herself to a powerful therapist.

Using hypotheses derived from Bowlby and Mahler, Stone (1980) tested 46 women who were sexually involved with therapists to determine if it was related to their:

pre-Oedipal needs to merge with the mother. In order to preserve a symbiotic attachment, deny feelings of separateness, and defend against object loss, the female patient attempt[s] to fuse with the therapist through sexual contact. (pp. XVI and XVII)

In fact, Stone did find that the women who were most sexually vulnerable had the greatest anxious attachments to their mothers, their present boyfriends, and to their therapists. Thus, sexual vulnerability was related to the client's anxious attachment.

These data give additional support to the conclusion that the client's sexual involvement with their therapist was a result of

transference issues, and not only a result of the real, present relationship. Interestingly, this finding would suggest that it would be inaccurate to relate the client's transference (with the male therapist) only to the father. With Stone's (1980) study, for instance, it focuses on the broad area of attachment, which is at least as much a maternal as paternal transferential issue. One limitation of this study should be noted, however. Stone's (1980) study was used to validate some of the instruments used. Therefore, the instruments used to measure these constructs have limited testing by which they have been validated. In other aspects the study was well constructed and carried out, which allows for the provisional acceptance of her conclusions.

It is clear that the psychodynamic notion that sexual intimacy in psychotherapy is a result of the transference of the client can account for the research data, at least with female clients and male therapists. Also, the concept that sexual intimacy is the result of a status/power differential can account for much, but not all of the data, e.g. attachment. Both of these perspectives may be useful, however, in shedding light on issues related to sexual intimacy in psychotherapy. This will be explored more fully in the next section.

Male client/female therapist and homosexual client/therapist relationships are infrequent and do not have enough research to make any such conclusions. However, Stone's (1980) data on attachment suggests that many of the dynamics may be similar,

since attachment is a broad parenting issue not exclusive to men or women. In male client/female therapist sexual relationships, it is possible that status/power is an especially important issue. For homosexual client/therapist relationships, it may be that there are specific issues related to the same or opposite-sex parent, as some of the literature on homosexuality suggests (e.g. Moberly, 1983). For now, we can only speculate.

The present discussion is, however, only half of the picture. In the next section, both the theoretical notion of countertransference and the status/power concept will be evaluated in light of their ability to account for the data on the therapist's role in the therapeutic relationship that becomes sexualized.

Countertransference and Status: The Therapist's Role

Countertransference is transference in reverse. The therapist's unresolved early conflicts unconsciously cause him to infuse the client with characteristics that reflect his own past experiences rather than to constitute reactions to the patient's actual behavior (Ruesch, 1961). Greenson (1968) elaborates:

Errors due to countertransference arise when the analyst reacts to his patient as though the patient were a significant person in the analyst's early history. Countertransference is a transference reaction of an analyst to a patient, parallel to transference, a counterpart of transference.... Countertransference reactions can lead to a persistent inappropriate behavior toward the patient in the form of constant misunderstanding or some unconscious rewarding, seductive [italics added] or permissive behavior by the analyst. (p. 348)

Freud's groundbreaking paper "Further Recommendations on the

Technique of Psychoanalysis: Observations on Transference Love" (1915/1963) was the basis for later conceptualizations that sexual intimacy in psychotherapy was partly the result of therapist countertransference. He argued that such involvement by the therapist evolved out of the needs of the therapist (countertransference) as his needs were brought out by the therapeutic situation.

Virtually every theoretical writer on the subject of client/therapist sexual intimacy has conceptualized the process in much the same way (Tower, 1956; Masters and Johnson, 1970; Dalberg, 1971; Chesler, 1972; Pope et al., 1986). However, there has been no clear attempt to date to link the empirical findings with this interesting clinical/psychodynamic notion. As noted previously, some recent researchers have also suggested that sexual intimacy in psychotherapy is the result of differential status and power in our society. The following will explore these areas, focusing again on male therapist/female client relationships.

Butler (1975) interviewed a group of 20 psychologists and psychiatrists who had sexual intimacies with patients. He noted that 90% of the therapists whom he studied said they were vulnerable, needy, or lonely at the time the relationship began. They were likely, then, to act on past/conflictual (countertransference) or present themes of personal needs with clients. Also, their high status role as therapist made it easy

for them to direct the relationship to sexuality. Further, 45% of the therapists reported having used rationalizations to permit the sexual intimacy as part of the therapeutic process.

A manifestation of the distortion of perception that occurs in therapist/client sexual relationships is shown in data from Butler's (1975) study. A portion of his sample of sexually intimate therapists (25%) terminated therapy when the sexual intimacy began, noting that relationships that involve both sex and therapy were exploitive to the client. In a later part of the interview, these therapists were asked about the need for referral in case of sexual intimacy. Half (50%) of this group stated that referral should be made. However, not one of these therapists actually referred the clients that they had been sexually involved with. Zelen (1985) concluded that this discrepancy was the result of a "neurotic resistance or fear of exposure or both" (p. 184) on the part of these therapists. This is confirmed by Pope et al.'s (1986) finding that the overwhelming majority of therapists did not act out sexual attraction with clients due to the fact that they considered it unethical, rather than self-serving reasons such as fear of negative consequences. Interestingly, 80% of the therapists in Butler's & Zelen's (1977) study were not able to recall the events that lead up to the sexual relationship. It seems likely that the conflict involved in the recollection lead to this "blocking" and/or "repression."

Sexual intimacy with clients may not always be the result of a

therapist's attempts to overcome feelings of inadequacy and meet his own needs, though. It could be argued that sexual feelings are the result of the intimacy of the real, present relationship that develops during therapy. Therefore, the therapist is acting out his feelings of love and affection for the client. However, it is inappropriate for the therapist to use his professional role to meet his personal (legitimate) intimacy needs. This appears to be an abuse of the power and status that go with his role.

The behavior of these therapists confirms the idea that they are using their powerful role with "lower status" clients, i.e. women. For instance, Holroyd and Brodsky (1977) found that sexual intimacy is not associated with any particular theoretical orientation or with the use of touching (nonerotic) per se. Instead, they found that almost all erotic contact and intercourse was between a male therapist and a female client. In their later analysis (Holroyd and Brodsky, 1980), they noted that therapists who get involved sexually only touch their female clients, which they regard as a violation of roles based on a biased societal norm, i.e. that women are lower status. They assert that any psychotherapeutic measure that is reserved for one gender is suspect of being sexist. Since male therapists have a higher status due to the societal norm and due to their specific role in therapy (as the expert), Holroyd and Brodsky (1977) concluded that the belief that "erotic contact with patients is based on therapists' needs for power or sexual gratification seems

justified" (p. 849). Pope et al. (1979) also noted that "the predominant pattern is quite clear and simple: An older, higher status man becomes sexually active with a younger, subordinate woman" (p. 687).

The power differential is clearly present, e.g. Butler and Zelen (1977) found that 60% of the therapists perceived themselves as "father figures" to their patients and that remained unchanged after the sexual intimacy began. However, this status/power interpretation is incomplete to explain this phenomenon. While alternative hypotheses cannot be ruled out by these studies, they also lend support to the idea that the needs of the therapist (countertransference) are being acted out in the therapeutic situation, given our cultural/social context. The author believes that the theoretical concept of countertransference is able to account for more of the research data, i.e. these findings also reflect the male therapist's attempts to meet countertransference needs with his female clients. Just as clients seek out needs in socially approved ways (Forer, 1972), needy therapists seek out their needs in socially approved ways, i.e. sexually. Thus, therapists' countertransference needs for intimacy were expressed through the sexualized therapy relationship.

However, the concept of countertransference fails to address two issues. First, the intimacy of the therapy relationship that leads to the sexual attraction may be a component of the real, present relationship that develops. Second, if we do not take

into account the social sphere in which we live, we will not understand why therapists' countertransference needs are acted out in this way, i.e. the status/power differential in our society. Therefore, it seems most useful to see these as complementary, rather than competitive theories, since they make us sensitive to different issues.

Other findings also support this hypothesis. Butler and Zelen (1977) reported that unsatisfying marriages, recent separations, and/or divorces were correlated with the beginning of sexual intimacies with clients. Thus, it seems that the therapists shifted the sources of gratification to their clients during this vulnerable or needy time. Further, 55% of their sample of therapists described themselves as frightened of intimacy. Sexualizing the therapy relationship provided an accessible (due to the status/power difference), though inappropriate (countertransference) way to have needs met due to the social/cultural differential. D'Addario (1977) concluded from her study that sexually involved therapists were experiencing a personal or professional crisis. Again, it is apparent that the therapist was acting out of personal needs inappropriate to the therapy relationship with the client (countertransference), in a setting conducive to acting out these needs (status/power difference).

Ishida (1974) postulated a number of factors that may be involved in therapist/client sexual intimacy. Unfortunately,

most of these factors still have not been evaluated by empirical evidence.

1. The "Hunter's Conquest Complex" or Don Juan syndrome. Male dominance/supremacy over subjugated, docile female. The need to demonstrate "masculinity."
2. Doubts of one's sexuality and masculinity, hence the need for reassurance.
3. Dissatisfaction at home. Inadequacy either of self or spouse, or both.
4. Genuine interest in giving the patient sexual satisfaction—Master of Lovemaking complex ("Other men are not as good as I am" at arousing women).
5. Curiosity about other women's sexual performance.
6. Opportunistic. [sic]
7. Weakness—succumbing to temptation of a "seductress."
8. Father-daughter incest (the young female often representing the daughter figure). (p. 103)

This is not a complete list, but does demonstrate the wide variety of factors that could lend themselves to a therapist's involvement in sexual intimacy with clients. While there is a rich supply of theoretical literature (e. g. Marmor, 1972; Dalberg, 1971), the broad range of factors that have been postulated are beyond the scope of the available data. However, an underlying factor in all of them are the needs of the therapist (countertransference), that the social situation has allowed to be acted out in this way (due to the status/power differential).

While transference seems to be a more comprehensive overarching construct, the status/power notion is helpful in keeping researchers aware of the power issues in the present relationship in therapies that includes sex. This perspective increases our recognition the abuse that may occur in the midst of the present, realistic relationship that develops. Therefore, it

is useful to utilize both perspectives in evaluating and directing research.

Zelen (1985) portrays the sexually intimate therapist as "vulnerable... who served his own needs by sexualizing the therapeutic relationship" (p. 182). In his review of the literature, he concludes that "these clinicians were not acting as therapists; rather they were engaged in self-serving, need-fulfilling behavior which had high reinforcement value for them..." (p. 183). He notes that in our "stressful profession, with such a high suicide rate, unmet needs for affection and intimacy, not necessarily [just] sexual, can be devastating if left untouched" (p. 184). This leads us to consider what has and should be done about the problem of sexual intimacy in psychotherapy.

Strategies in Dealing with the Problem of Sexual Intimacy

Researchers have found that only 9%-22% of psychologists report having had adequate training in dealing with sexual attraction to clients, while 55% reported having no education at all (Glaser & Thorpe, 1986; Pope et al., 1986). This finding indicates that therapists do not get training in graduate school (as previously shown by Holroyd, 1983; Kenworthy, Koufacos & Sherman, 1976; and Landis, Miller & Wettstone, 1975) or in continuing education. So how can the profession deal with this continuing problem?

Most authors have suggested that education is the key to

dealing with sexual intimacy (e.g. Bouhoutsos, 1985; Glaser & Thorpe, 1986). Pope et al. (1986) tried to support the efficacy of education by highlighting their finding that most therapists report refraining from sexual intimacies with clients due to the belief that such behavior is unethical. They suggest that "personal ethics and a regard for client welfare are more compelling than fear of negative consequences as reasons for refraining from sexual intimacies with clients" (p. 156). Unfortunately, their results provide no clear-cut evidence for such a conclusion. Most psychologists do not engage in sexual intimacies with clients, so the most that can be concluded is that more psychologists cited these reasons as why they refrained from sexual intimacy. Pope et al. report no breakdown, however, between those psychologists who actually become involved in sexual intimacy and those who do not. Therefore, there is no basis for concluding that these characteristics are distinctive to psychologists who refrain from sexual intimacies with clients.

Two extreme external sanctions have thus far been taken in an effort to restrict sexually intimate behavior in therapy. First, there has been an increase in civil and there is likely to be an increase in criminal legislation. Some of the implications of this have been noted previously, so it is sufficient to state that the negative consequences for sexual intimacy with clients has increased. Second, in one state a law has been enacted which requires therapists, who are informed by their clients of sexual

involvement with a prior therapist, to report their colleagues to the licensing board (i.e. Minnesota's "Vulnerable Adults Act"). While such a law forces the sexual intimate therapist to be confronted by his/her behavior, it is confounded by the erosion of the client's confidentiality (Bouhoutsos, 1985). Obviously, the break in confidentiality has the potential for seriously disrupting the therapeutic relationship, especially since the previous therapeutic relationship has been negative and trust has been undermined.

Bouhoutsos (1985) suggests that negative consequences and cognitive restructuring have proved to have little effectiveness in deterrence. This makes intuitive sense in light of continued sexual intimacy despite increasing civil and criminal constraints. However, what is useful in preventing sexual intimacy remains unclear.

It does make sense, though, to avoid exclusive dependence on a system of external sanctions for restraining sexually intimate behavior. Formal training provides for the opportunity to have values internalized as well as making one aware of the consequences of one's behavior (Kohlberg, 1969). Further, education is the only preventative measure that is available to the profession. However, Pope et al. (1986) point out some of the problems that has prevented education, e.g. the limited amount of research and reluctance to deal with the issue of sexual intimacy in psychotherapy.

Despite these problems, there are several steps that could prove useful in a training program. These steps could be helpful in taking the focus from blaming to prevention. Some of these relate directly to our clients. First, it is necessary to think of clients in diagnostic terms as to their sexual vulnerability. Therapists must be able to recognize potentially problematic clients. Certain clients will have needs that pull for sexual intimacy, as shown in the section on transference. Second, therapists should be aware that their clients are often needing something other than sex when encouraging sexual intimacy, e.g. being held (Forer, 1972). Third, professionals should work at educating the public as to their rights as consumers of psychotherapy (Bouhoutsos, 1985). Fourth, psychologists should be working at changing the social/cultural situation, in which women have lower status, that allows for the perpetuation of women as targets of sexual abuse in therapy.

Other prevention steps refer to the therapist himself. Primarily, it is helpful to remember that all therapists are at risk for sexual attraction to their clients, simply because of the intimate nature of the therapeutic relationship. Heightened awareness of the problem will enable the helping professions to drop the false model of omniscience and omnipotence (Zelen, 1985). Though these feeling may be "real," behavior which seeks to gratify these needs is not appropriate to the purpose of therapy. Therefore, a training approach must acknowledge the value of

honest, serious discussions about therapists' attraction to clients (Pope et al., 1986). Also, sexual attraction should be addressed throughout the curriculum of graduate training, not merely in a class on ethics. Finally, students should not be made to feel that they are "impaired" or seductive if they discuss sexual attraction to clients with their supervisors. Graduate training should be a safe environment in which to deal with these feelings.

Secondarily, therapists need to take a self-inventory of their sexual and intimacy needs on a regular basis. Is the therapist satisfied? Is (s)he getting his sexual and intimacy needs met outside of his or her professional role? All therapists must recognize that if they are in a personal or professional crisis, which causes vulnerability to increase, (s)he may not be able to cope with sexual attraction to clients as well as at other times in his or her career.

We must exercise caution in assuming that education is the panacea for dealing with sexual intimacy in psychotherapy. Like the use of monitoring (through close supervision) that has traditionally been used to control this behavior, education has not been empirically validated as effective. The profession needs to focus in on this problem through education. Then, we need to follow this up with a long-term study to determine if our intervention methods are effective.

In conclusion, there are no simple answers to the problem of

how to deal with the sexually intimate therapist. The emerging literature on "impaired practitioners" of psychotherapy is applicable and will likely prove a useful resource (Wood, Klein, Cross, Lammers & Elliott, 1985; Lalotis & Grayson, 1986). As noted by Kutz (1986):

For each situation, the appropriateness of rehabilitation (psychological and/or medical treatment), monitoring (close supervision), discipline (suspension or revocation or license), or any combination thereof should be based on a diagnostic assessment of the incompetent behavior. (p. 220)

Future Research Strategies

There is a need for more research in the area of sexual intimacy in psychotherapy. It is hoped that this brief critique will provide a focus for future research, to make such research more valuable.

Holroyd and Brodsky's (1977) national survey was an important contribution. It was the first survey of psychologists attitudes and practices of sexual intimacy in psychotherapy. However, they presented virtually no data that distinguished the sexually intimate therapist from therapists in general. Not until three years later (Holroyd and Brodsky, 1980) did they present information regarding sexually intimate therapists. It was unfortunate that the profession had to wait three years to obtain published information on the area that appears to be most useful in dealing with the problem of the sexually intimate psychotherapist. While knowledge of incidence is very important, the key to effectively dealing with the problem is ferreting out

the distinctive characteristics of the sexually intimate therapist. This is vital for identification and education/rehabilitation of such therapists.

Similarly, Pope et. al.'s (1986) contribution was very important in normalizing the experience of sexual attraction to clients (i.e. 87% of psychologists have been sexually attracted to clients). However, there were few distinguishing characteristics of the sexually intimate therapist reported. Again, the researchers seem to be ignoring this crucial issue in regard to sexual intimacy in psychotherapy. If their percentages are broken down, it is apparent that they have data on at least 36 therapists who have acknowledged sexual intimacy. It is hoped that by highlighting this issue, this data will not be ignored or untapped. Further, it is recommended that future research make this area an explicit focus. The existence of sexual attraction toward clients has been normalized and sexual intimacy with clients is now an acknowledged fact within the profession. Therefore, future research can focus on how to deal with this problem.

Zelen (1985) noted some other important directions for future research. One, it would be useful to compare patients who terminate therapy immediately upon being propositioned with those who lingered, to gain evidence of patient strengths and weaknesses. Two, comparisons should be made between those patients who continued the intimate relationship with those who stopped the intimate relationship, but continued with the

professional relationship. Third, the profession needs enough research data to give us a clearly defined "risk factor" for a patient as well as a "risk factor" for a therapist (p. 185).

Researchers must also be willing to explore the long-term effects on the clients who have been involved in sexual intimacies with their therapists. This will require researchers to come up with creative ways of identifying clients who feel that the experience was not negative. Ultimately, this will be useful in sorting out what distinguishing characteristics these clients have and if there are negative effects that they are not aware of.

Summary and Conclusions

The goal of this paper has been to review sexual intimacy in psychotherapy, particularly with regard to female clients and male therapists. The literature on the incidence of sexual contact with clients has shown that this is a significant problem in the profession, involving 5%-10% of psychologists. Further, male therapists are involved in sexual intimacies significantly more often than female therapists (approximately 9% vs. 2%). The definition of sexually intimate behavior has varied, but is presently defined as genital stimulation and/or intercourse. While this definition is unambiguous, it has been noted that this fails to address other behaviors that may be considered sexually intimate, e.g. kissing.

In light of rapidly changing sexual mores it was also noted that prohibitions against sexual intimacy in psychotherapy may be

considered arbitrary moral or theoretical standards if not supported by empirical evidence. The research clearly shows that the overall effects of sexual intimacy are negative, with results as high as 90% (Bouhoutsos et. al., 1983) reported. Specifically, negative effects have ranged from difficulty in trusting a subsequent therapist to suicide.

Further, an evaluation was made to determine whether the theoretical constructs of transference of the client and countertransference of the therapist and social status/power could account for the data in the area of sexual intimacy. It was concluded that the theoretical constructs can, in fact, account for the research data. The sexualized therapeutic relationship appears to arise out of the vulnerabilities and/or conflicts of both the client (transference) and the therapist (countertransference). Also, the transference/countertransference schema was shown to be able to account for more of the data than the notion of a status/power differential. However, the status/power concept was shown to be useful in focusing on the abuse that may occur in terms of the present, real relationship in therapy. Also, it increases the sensitivity of the researcher to the cultural situation that allows therapists' countertransference needs to be acted out through sexual intimacies with their clients. Therefore, these were seen as complementary, rather than competing theories.

A brief evaluation of how to deal with the problem within the

profession was also presented. Two extreme external sanctions have been enacted. First, there has been an increase in civil and criminal legislation against therapists who are sexually intimate with clients. Second, laws have been enacted which require therapists who are informed by their clients of sexual involvement with a previous therapist to report their colleagues to the licensing board. This intervention is complicated by the erosion of confidentiality that occurs. Education has been put forth as a more practical intervention, particularly because it has preventative value.

Two steps were noted as necessary to prevention. First, the clinician should take a diagnostic approach to recognizing clients who are likely to be vulnerable to acting out sexually in therapy. Second, the therapist needs to take regular self-inventories of his or her own intimacy needs, to be aware of their increased vulnerability in times of stress. However, it was noted that the effectiveness of education or any other means of dealing with this problem has not been empirically validated. Also, it was suggested that the emerging literature on "impaired practitioners" of psychotherapy will likely be a useful tool in planning intervention strategies for those therapists who have already been involved in sexual intimacies.

The final section of the paper was a brief critique of the research in sexual intimacy. It was pointed out that we have normalized the experience of sexual attraction to clients and

proven the incidence sexual intimacy. However, much of the research has missed a crucial issue, i.e. uncovering the distinguishing characteristics of the sexually intimate therapist. Also, long-term studies must be done to determine the effects of our intervention strategies as well as the effects on clients, particularly those who perceive no negative effects. It was suggested that this information would help plan education and intervention strategies.

In closing, it is important to note a few limitations of this study. First, this review has focused on male therapist/female client sexual relationships. Although this is the area of greatest incidence and research and therefore justified in such a review, the problems associated with female therapist/male client and same-sex relationships are worthy of similar attention. As more research becomes available and more women enter the profession, it will be important to determine if the dynamics are similar or different. Second, a rich store of theoretical literature on the subject of sexual intimacy in psychotherapy has not been discussed here (e.g. Blum, 1971; Marmor, 1972; Scheflen, 1965). Due to the limited state of the research, these areas simply have not yet been addressed by the available data.

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